

NEVADA STATE BOARD OF MEDICAL EXAMINERS

SPECIAL VOLUNTEER MEDICAL LICENSURE

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications, which appear to have been altered in any form, will not be accepted. Applications must be printed in black ink and received on single sided white bond paper, 8 ½" x 11" in size and must be typed or printed legibly.

With the issuance of a Special Volunteer Medical License, the applicant acknowledges that;

- A physician who is retired from active practice and who:
 - (a) Wishes to donate his expertise for the medical care and treatment of persons in this State who are indigent, uninsured or unable to afford healthcare; or
 - (b) Wishes to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization, may obtain a special volunteer medical license by submitting an application to the Board and
- That the physician will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation for providing medical care under the Special Volunteer Medical License, except payment by a medical facility at which the physician provides volunteer medical at the expense of the physician for necessary travel, continuing education, malpractice insurance, or fees of the Nevada State Board of Pharmacy
- During the application process of a Special Volunteer Medical License the physician must provide proof that he has previously been issued an unrestricted license to practice medicine in any state of the United States and that he has never been the subject of disciplinary action by a medical board or any other jurisdiction

-The initial Special Volunteer License expires 1 year after the date of issuance. The license may be renewed and any license that is renewed expires 2 years after the date of issuance.

-The retired physician must be competent to practice medicine

-No fee is required for a Special Volunteer Medical License, however there is a non refundable Criminal Background Investigation fee of \$75.00

-A physician with a Special Volunteer Medical License must comply with the CME requirements for registration renewal which is the following: 40 hours of continuing medical education during the preceding 24 months, 2 hours must be in medical ethics and 20 hours of which must be in the scope of practice or specialty of the holder of the license. The CME must be Category 1 and approved by the AMA.

**Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180 (3).
The Criminal Background Investigation fee will not be refunded.**

Per Nevada Revised Statute 630.175, "an applicant for a license or a licensee shall report to the board within 30 days any fact which would render any statement to the board by the applicant or licensee false, misleading, inaccurate or incomplete".

Per Nevada Revised Statute 630.161, "The board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction".

The board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances warranting a personal appearance at a board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application.**

Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

- ** You may be required to personally appear before the board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.**
- ** You may be required to personally appear before the board for acceptance of your application for licensure if you have answered in the affirmative (“Yes”) to questions 8, 9, 10, 11, 12, 13, 14, 19, 27, 28, 29, 30, 31, 32, and 33**

If, at the time you meet with the board, the board votes to deny your application for licensure, this denial of your application becomes a reportable action to the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT:

- _____ a. Properly completed, signed and notarized application, pages 1 – 6 and \$75 non refundable Criminal Background Investigation fee;
- _____ b. Recent photo (at least 2"x 2") attached to application, signed in ink on lower edge of photograph;
- _____ c. Complete mailing addresses of all hospital staff memberships;
- _____ d. Month and year for all internships, residencies and fellowships;
- _____ e. Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 13a, 14, 19, 27, 28, 29, 30, 31, 32 and 33;

(Examples: If you have ever been a defendant in a legal action involving professional liability (malpractice), whether or not you have ever had a settlement paid on your behalf, you should answer affirmatively to question #12 and / or 12a, and submit the appropriate documentation.

If you have ever had any actions, restrictions or limitation or imposed on you, or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #19 and submit the appropriate documentation.

If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violation of a statute, rule or regulation governing your practice as a physician, you should answer affirmatively to question #31 and submit the appropriate documentation.)

- _____ f. U.S. born citizens – certified copy of Birth Certificate that bears an original seal of the issuing agency (notarized copies are not acceptable);
- _____ g. Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport;
- _____ h. Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;
- _____ i. Release form, signed and notarized (Form A);
- _____ j. Self-query responses from the National Practitioner Data Bank (NPDB) AND the Healthcare Integrity and Protection Data Bank (HIPDB), see enclosed instruction sheet. The NPDB and HIPDB will send their reports directly to the applicant and the applicant will forward both reports to the board office;
- _____ k. Form B must be returned to the Board office with completed application for licensure;
- _____ l. Copy of ABMS Board certification certificate, copy of ABMS Board re-certification certificate;
- _____ m. 4 hours bio-terrorism AMA Category 1 CME relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction (NRS 630.253 2(b)).
- _____ n. A letter indicating that the physician is applying for a Special Volunteer Medical License and the physician will exclusively devote medical care to the indigent persons or to provide services for any disaster relief operations conducted by a governmental entity or nonprofit organization. The letter must indicate name and address of the organization in which he will be volunteering and that he will not receive *any* payment or compensation, either direct or indirect, or have expectation of any payment or compensation for providing medical care under the Special Volunteer Medical License, except payment by a medical facility at which the physician provides volunteer medical services at the expense of the physician for necessary travel, continuing education, malpractice insurance, or the fees of the Nevada State Board of Pharmacy.

(Revised 2/4/2010)

APPLICATION CHECKLIST

TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE:

(Verifying agencies may charge a fee)

- _____ a. Certificate of Medical Education (Form 1) to be completed by medical school(s) and forwarded directly to the Board office;
- _____ b. Official transcripts from all schools where professional medical instruction was received (if transcripts are not in English, an original, certified and official English translation is required);
- _____ c. Certificate of Completion of Progressive Postgraduate Training (Form 2) sent to ALL institutions where any training occurred (internship, residency, fellowship and research fellowship);
- _____ d. Certification of National Board, FLEX, USMLE and SPEX scores request form or instructions enclosed OR state written examination certification Form 4 if applicable. For LMCC, call (613) 521-6012;

On June 17, 2008

NAC 630.080 is hereby amended to read as follows:

NAC 630.080 Examinations (NRS 630.130, 630.160, 630.180, 630.318)

1. For the purposes of paragraph (e) of subsection 2 of NRS 630.160, an applicant for a license to practice medicine must pass:

3. For the purposes of subparagraph (3) of paragraph (c) of subsection 2 of NRS 630.160, a person must pass Steps I, II and III of the United States Medical Licensing Examination within 7 years after the date on which the person first passes any step of the United States Medical Licensing Examination and a person is limited to a combined maximum of 9 attempts to pass steps I, II and no more than three attempts at step III of the United States Medical Licensing Examination.

- _____ e. Verification of board certification, if applying via state written exam/board certification;
- _____ f. License verification (Form 3) from all states where applicant is currently licensed or has ever been licensed;
- _____ g. Status report from the Educational Commission for Foreign Medical Graduates (ECFMG), use enclosed request form;
- _____ h. Form 5 to be completed by appropriate entity and returned directly by the verifying institution to the Board office;
- _____ i. Form 6 to be completed by appropriate entity and returned directly by the verifying institution to the Board office, which includes a loss history report;
- _____ j. Letter from the organization which the physician will volunteer indicating that the physician will exclusively provide medical care to indigent persons in the State of Nevada and the location of the organization. The organization must indicate that the physician will not receive any payment or compensation for providing medical care under the Special Volunteer Medical License, except for payment by a medical facility at which the physician provides volunteer medical services at the expenses of the physician for necessary travel, continuing medical education, malpractice insurance, or fees of the Nevada State Board of Pharmacy;
- _____ j FBI Criminal history background report – returned directly by the verifying institution to the Board office.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners,
P.O. Box 7238, Reno, NV 89510
Or
1105 Terminal Way, Ste 301, Reno, NV 89502
(775) 688-2559

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete, or that you have omitted vital information.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your honesty before the entire Board of Medical Examiners. This includes a sanction or disciplinary action you may have experienced during medical school or your postgraduate training, or any conflict you may have had with the legal system — even if the charge(s) has been expunged, lessened, or dismissed and no matter how long ago it occurred, the FBI will have your fingerprints on file. This will be discovered.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, **ASK YOUR LICENSING SPECIALIST.** Our licensing specialists are here to help you.

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I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

**INSTRUCTIONS FOR REQUESTING EXAM SCORES
"BOARD ACTION HISTORY REPORT" AND
NPDB/HIPDB "SELF QUERY"**

**INSTRUCTIONS FOR OBTAINING THE NATIONAL PRACTITIONER DATA BANK AND
HEALTHCARE INTEGRITY AND PROTECTION DATA BANK'S "PRACTITIONER
REQUEST" FOR INFORMATION DISCLOSURE (SELF-QUERY):**

The request form for the NPDB and HIPDB is available on the NPDB/HIPDB website at <http://www.npdb-hipdb.com/welcome.sq.html>

Once you reach the web site, you will be in the "self query service" module of the NPDB/HIPDB web site. You will need to click on "Perform a "self-query" in the center of the page, then click on "Individual Self-Query" and follow the instructions provided. If you require additional information, please call the NPDB/HIPDB at (800) 767-6732.

NOTE: Once you have received the NPDB and HIPDB self-query responses, forward **both** of them to the Board office.

INSTRUCTIONS FOR OBTAINING AN EXAMINATION SCORE

**(FLEX, SPEX, and USMLE scores) AND (BOARD ACTION HISTORY REPORT (EBAHR) FROM
THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES, INC.**

The Federation of State Medical Boards of the United States, Inc.'s EBAHR will certify a complete history of your scores for a designated examination(s). The Federation maintains scores for FLEX, SPEX, and the USMLE Steps 1, 2, and 3.

The request form for the EBAHR is available on the FSMB web site at www.fsmb.org.

Once you reach the FSMB web site, click on "Transcripts Requests", then "EBHAR Form" and follow the instructions for requesting the scores.

INSTRUCTIONS FOR REQUESTING NATIONAL BOARD SCORES:

The request form for the National Board of Medical Examiners is available on the NBME web site at <http://www.nbme.org/pdf/endorse.pdf>. If you are unsuccessful in downloading or printing this form, or do not have access to a computer, please send to the NBME a signed, written request for your scores which includes the state to which you are applying, your name (please print), USMLE ID# or NBME ID# or SSN, date of birth, current address, phone number and e-mail address (if applicable). Include \$50 for one endorsement and \$5 for each additional endorsement requested at the same time. Make your check payable to NBME and mail to:

NBME
PO Box 48014
Newark, NJ 07101-4814.

For additional information, please call the NBME Examinee Records office at (215) 590-9592.

LMCC EXAMINATION TRANSCRIPT OF SCORES

Navigate to this website: www.mcc.ca

Click on **English**; go to **Licentiate** on the menu line; then go to **Certified Transcript of Examinations**.

Then click on **Service Request Form**.

Print the Service Request Form and complete it. Mail it along with your check to the address on the top of the form. Or, if you are paying by credit card, you can fax the form to the fax number located on the form itself and also on the instruction page.

INSTRUCTIONS FOR REQUESTING ECFMG VERIFICATIONS

International medical graduates must contact the ECFMG for certification status to be sent to the Nevada State Board of Medical Examiners. You can contact ECFMG's Applicant Information Services at (215) 386-5900.

The request form can be found on ECFMG's website at www.ecfm.org

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; revocation, suspension or other modification of previous license; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
2. Conviction of violating any of the provisions of NRS 616D.200, 616D.220, 616D.240, 616D.300, 616D.310, or 616D.350 to 616D.440, inclusive.
3. The revocation, suspension, modification or limitation of the license to practice any type of medicine by any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if such malpractice is established by a preponderance of the evidence.
5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when such a failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a national code of ethics adopted by the Board by regulation.
10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.

(Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265)

NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
 2. Advertising the practice of medicine in a false, deceptive or misleading manner.
 3. Practicing or attempting to practice medicine under another name.
 4. Signing a blank prescription form.
 5. Influencing a patient in order to engage in sexual activity with the patient or with others.
 6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
 7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.
- (Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:
 - (a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
 - (b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
 - (c) Referring, in violation of NRS 439B.425, a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
 - (d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
 - (e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
 - (f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
 - (g) Failing to disclose to a patient any financial or other conflict of interest.
 - (h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for his medical education.

2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of NRS 636.373.

(Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

Cont.

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of statute or regulation governing practice of medicine; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient; lack of skill or diligence; filing of false report; habitual intoxication; failure to report modification of license in another jurisdiction. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
 2. Engaging in any conduct:
 - (a) Which is intended to deceive;
 - (b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
 - (c) Which is in violation of a regulation adopted by the State Board of Pharmacy.
 3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in chapter 454 of NRS, to or for himself or to others except as authorized by law.
 4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
 5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he is not competent to perform.
 6. Performing, without first obtaining the informed consent of the patient or his family, any procedure or prescribing any therapy which by the current standards of the practice of medicine are experimental.
 7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
 8. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
 9. Failing to comply with the requirements of NRS 630.254.
 10. Habitual intoxication from alcohol or dependency on controlled substances.
 11. Failure by a licensee or applicant to report, within 30 days, the revocation, suspension or surrender of his license to practice medicine in another jurisdiction.
 12. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to NRS 630.318.
- (Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
 2. Altering medical records of a patient.
 3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
 4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.
 5. Failure to comply with the requirements of NRS 630.3068.
 6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board.
- (Added to NRS by 1985, 2223; A 1987, 199; 2001, 767; 2002 Special Session, 19; 2003, 3433)

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
 2. Willful failure to comply with:
 - (a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
 - (b) A court order relating to this chapter; or
 - (c) A provision of this chapter.
 3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of NRS 439B.410.
- (Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

APPLICATION FOR LICENSURE

License No. _____

NEVADA STATE BOARD OF

MEDICAL EXAMINERS

File No. _____

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

(For Board Use Only)

1. Present Legal Name _____
 Last First Middle Maiden

List any other name(s) ever used _____

2. Business and/or Mailing Address _____
 Street City County State Zip

3. Home Address _____
 Street City County State Zip

4. Telephone Number (_____) _____ (_____) _____ Fax Number (_____) _____
 Office Home
 Cellular Number (Optional) _____ Email _____

5. Date of Birth _____ Place of Birth _____ Gender ____ F ____ M
 (Month / Day / Year) (City , State , Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____
Submit a certified copy of birth certificate or original Certificate of Naturalization or current U.S. passport or copy of the front and back of your alien registration card, Employment Authorization or Visa. Please note: Copy of document authorizing a name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Height _____ Weight _____ Color of Eyes _____ Color of Hair _____

NRS 630.165(3) An application submitted pursuant to subsection 1 or 2 must include the social security number of the applicant;

NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR WRITTEN EXPLANATION(S) ON A SEPARATE SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR LICENSURE FORM.

8. Do you currently have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No
9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? _____ Yes _____ No
10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety? _____ Yes _____ No
11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education? _____ Yes _____ No

12. Have you EVER been named as a defendant, or been requested to respond as a defendant or potential defendant, to a legal action involving professional liability (malpractice?) (If "Yes," attach explanation on separate sheet.) _____ Yes _____ No

12a. Have you had a professional liability (malpractice) claim paid on your behalf, or paid such a claim yourself (Including any military tort claims if applicable)? _____ Yes _____ No

13. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense related to the manufacture, distribution, prescribing, or dispensing of controlled substances *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement. (If "Yes," attach explanation on separate sheet.) _____ Yes _____ No

13a. Have you been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any criminal offense other than a criminal offense listed in question #13? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, sealing of a record, or expungement. _____ Yes _____ No

14. Have you previously applied for medical licensure in Nevada (including a residency program)? _____ Yes _____ No

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**

Name	City/State	Place Where Instruction Received	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application, if more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:

Medical School Name	City/State	Exact Date of Issuance
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17. List all ACGME* approved graduate medical education you have received as an intern or resident in the United States or Canada.

*Accreditation Council for Graduate Medical Education

Postgraduate Year	Hospital/ Institution	City/State	Specify (I = Internship or R = Residency (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application, if more space is needed, please attach separate sheet.)

18. List all non – ACGME Fellowship training programs attended in the United States or Canada.

Institution	City/State	Type of Fellowship	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application, if more space is needed, please attach separate sheet.)

19. Have you EVER been the subject of an investigation (including matters that resulted in no adverse action or outcome to you) have you resigned, been dismissed, or have any actions, restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program? (If "Yes," attach explanation on separate sheet.) _____ Yes _____ No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: _____

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained, (also include any failed examinations).

21a. NATIONAL BOARDS: (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores)
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21b. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores) (FLEX weighted average)

21c. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Part Taken	Date (Mo/Yr)	Results (Two Digit Scores)

21d. LMCC (Licentiate of the Medical Council of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMINATIONS.)

Location	Date (Mo/Yr)	Results (Scores)

21e. State Written Examination:

Location	Date (Mo/Yr)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Location	Date (Mo/Yr)	Results (Two Digit Scores)

22. State your scope of practice specialty(ies):

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES.**

Specialty Board	Certification #	Dates of Certification/Recertification (Mo/Yr)

24. Account for, in **chronological order**, all activities since graduation from medical school. **ALL PERIODS OF TIME MUST BE ACCOUNTED FOR.**

Activities	Location (City/State/Country)	From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

25. List below the requested information for all hospitals in which you **ARE, OR HAVE EVER BEEN** a staff member at any level during the last ten years. If none, please indicate. Do not list internship, residency or fellowship affiliation.

Hospital	Complete Mailing Address	Dates of Appointment From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

26. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country.

State/Territory Country	License #	Exact Date of Issuance	Dates of Practice From (Mo./Yr.)	To (Mo./Yr.)

(All information must begin on the application, if more space is needed, please attach separate sheet.)

27. Have you ever been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____ Yes ____ No

28. Have you ever had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____ Yes ____ No

29. Have you ever voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory? (If "Yes," attach explanation on separate sheet.) ____ Yes ____ No

30. Have you ever been denied membership, asked to resign or expelled from a medical society or other professional medical organization? (If "Yes," attach explanation on separate sheet.) ____ Yes ____ No

31. Have you ever been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or other agency other than the Nevada State Board of Medical Examiners? (If "Yes," attach explanation on separate sheet.) ____ Yes ____ No

32. Have you ever surrendered your state or federal controlled substance registration or had it revoked or restricted in any way? _____ Yes _____ No
(If "Yes," attach explanation on separate sheet.)

33. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (Please Note: Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital	Mailing Address	Type of Action	Dates of Action From (Mo./Yr.) To (Mo./Yr.)
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(All information must begin on the application, if more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

_____ (a) I am not subject to a court order for the support of a child;

_____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

_____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

I, _____ being duly sworn, depose and say:
That the answers to the foregoing questions and statements made in the above application as well as any and all further explanations contained on any separate attached pages are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

(signature of applicant)

(date)

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

By: _____

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____

Signature of Notary: _____

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT
QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN
THE LAST SIXTY (60) DAYS AND BE AT LEAST
2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE
LOWER PORTION OF ITS FRONT SIDE.

**PROOF PHOTOS, NEGATIVES AND DIGITAL PHOTOS
ARE NOT ACCEPTABLE.**

***CENTER AND ATTACH
PHOTOGRAPH HERE.***

I hereby certify that the attached photograph is a true likeness of myself taken within the last sixty (60) days.

(signature of applicant)

(date)

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present) business and professional associates (past and present) and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical and physical and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this

_____ day of _____, 2_____.

By: _____

Notary Public for State of: _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners

PO Box 7238

Reno, NV 89510

or

1105 Terminal Way #301

Reno, NV 89502

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to question #12 on the Application for Licensure, list all malpractice carriers, past and present.

Name of Insured: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

(If more space is needed, please copy this page or attach a separate sheet.)

**COMPLETE THIS FORM
ONLY IF APPLYING FOR
LICENSURE BY ENDORSEMENT**

State your Name, and fill in the State, territory, or District of Columbia in which licensed:

I, _____, being first duly sworn, do hereby swear or affirm under the penalties of perjury that the statements contained herein are true and correct to the best of my knowledge.

That I am now, and have been continuously licensed to practice medicine by the licensing agency of

_____, since _____.
(state, territory, or District of Columbia) (month / day / year)

That I have never had a license to practice any type of medicine in any jurisdiction, country, state, territory, or District of Columbia, revoked for gross medical negligence.

That I am the person named in the license to practice medicine in _____,
(state, territory, or District of Columbia)
and that said license to practice medicine was obtained by me without fraud or misrepresentation or any mistake of which I am aware, and that all information contained in this application for licensure by endorsement, and any accompanying materials are complete and correct.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

By: _____

Notary Public for State of: _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

Please return completed form to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno, NV 89510

or

1105 Terminal Way #301
Reno, NV 89502

Applicant: *Each medical school where instruction was received must complete this form. If more than one school was attended, photocopies of this blank form may be made and used.*

FORM 1

NEVADA STATE BOARD OF MEDICAL EXAMINERS CERTIFICATION OF MEDICAL EDUCATION

This certifies that _____
(name of applicant)

was enrolled in _____
(name of Medical School) (Location – City/State)

.....
To be completed by program only.

The undersigned further certifies that the records of this institution show that the applicant attended this institution from _____ to _____.
(month / year) (month / year)

Please check one: _____ The applicant was granted a medical degree by
_____ The applicant withdrew from
the above named Medical School on _____.
(month / day / year)

ADVANCED CREDITS – Credits Granted Upon Admission

(name of Medical or Professional School) (total credits) (dates attended)

Signed and the institutional seal affixed this

_____ day of _____, 2_____.

Affix Seal Here

By: _____
(typed name and title of President, Registrar or Dean)

(signature of President, Registrar or Dean)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners

PO Box 7238
Reno, NV 89510 or
1105 Terminal Way #301
Reno, NV 89502
(775) 688 – 2559

Applicant: Each institution where internship, residency and/or fellowship training was received must complete this form.
If more than one institution was attended, photocopies of this blank form may be made and used.

FORM 2

NEVADA STATE BOARD OF MEDICAL EXAMINERS CERTIFICATE OF COMPLETION OF PROGRESSIVE POSTGRADUATE TRAINING

Institution: _____ Affiliated University: _____

Address: _____

Name of Physician: _____

DOB: _____ SS#: _____ Medical School: _____

.....
The following information to be completed by program only.

IMPORTANT - Program Participation: Report incomplete postgraduate years (PGY) separately from those that were successfully completed. If the postgraduate year is currently in progress, report the expected completion in the "To" field. Report internships, residencies and fellowships separately.

PG/Year: _____ DEPARTMENT / SPECIALTY: _____

____ Internship
____ Residency From: ____/____/____ To: ____/____/____
____ Fellowship
____ Research Successfully completed?: ____ Yes ____ No ____ In Progress

PG/Year: _____ DEPARTMENT / SPECIALTY: _____

____ Internship
____ Residency From: ____/____/____ To: ____/____/____
____ Fellowship
____ Research Successfully completed?: ____ Yes ____ No ____ In Progress

PG/Year: _____ DEPARTMENT / SPECIALTY: _____

____ Internship
____ Residency From: ____/____/____ To: ____/____/____
____ Fellowship
____ Research Successfully completed?: ____ Yes ____ No ____ In Progress

Circle the correct response to the question below:

- Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME)? **Yes** **No**

Circle the correct response to the questions below: ("Yes" responses require written explanation.)

- Did this individual ever take a leave of absence or break from their training? If yes, please explain. **Yes** **No**

- Was this individual disciplined and/or placed under investigation or on probation? **Yes** **No**

Please explain below any "Yes" response(s) to the above two questions. If necessary, you may continue your explanation on a separate sheet of paper.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

Name: _____ Signature: _____

This section MUST be signed by the Program Director (M.D. or D.O. only)

Title: _____ Date of Signature: _____

Telephone: _____ Fax: _____ E-mail: _____

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238 OR 1105 Terminal Way, Ste 301
Reno, NV 89510 Reno, NV 89502

(775) 688 – 2559

Applicant: *Each state where licensure **is or ever was** held must complete this form. If more than one state, photocopies of this blank form may be made and used.*

FORM 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF STATE LICENSURE

PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: _____

Address: _____
(street) (apt. or suite #) (city) (state) (zip)

Date of Birth: _____
(month) (day) (year)

I am in the process of applying for medical licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the above address.

(signature of applicant)

PART 2 – TO BE COMPLETED BY LICENSING AGENCY

I certify that _____ who
(name of applicant)

graduated from _____
(name and location of Medical School)

on _____ was granted license number _____ by the state of _____
(date of graduation)

on _____ on the basis of _____
(date of issuance) (examination: NB / FLEX / USMLE / LMCC / State Licensing examination)

I certify that the above license is:

- _____ current, in good standing
- _____ not current, due to non-payment of fees
- _____ subject to pending disciplinary charges
- _____ subject to restriction of licensure or practice
- _____ other (please attach explanation)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of this form is deleted or modified, please attach an explanation.

(signature of certifying individual)

(title of certifying individual)

(licensing agency name)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238 OR 1105 Terminal Way, Ste 301
Reno, NV 89510 Reno, NV 89502
(775) 688 – 2559

Applicant: *This form to be completed ONLY if applying via state written examination with current ABMS certification.
This form is to be completed by the state licensing agency where examination was taken.*

FORM 4

NEVADA STATE BOARD OF MEDICAL EXAMINERS CERTIFICATE OF STATE LICENSING AGENCY EXAMINATION

I certify that _____ who
(name of applicant)

graduated from _____
(name and location of Medical School)

on _____ was granted license number _____ on _____
(date of graduation) (date of issuance)

on the basis of the licensing agency regular written examination of the state of _____.

I further certify that this physician passed the regular written examination given by this licensing agency on _____
(date)

and obtained a general average of _____ percent in the following subjects. A score of _____ is

considered a passing score.

Subjects of Examination	Percent	Subjects of Examination	Percent

I certify that this license is valid, current, has never been suspended or revoked, and will expire on _____;
(date)

OR this license was valid, was never suspended or revoked, and expired on _____.
(date)

NOTE: If any portion of the above certification is deleted or modified, please attach an explanation.

(type or print name and title of agency official) (name of state licensing agency)

(signature of agency official) (address)

(date) (phone number)

(affix licensing agency seal)

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238
Reno, NV 89510
(775) 688 – 2559

NEVADA STATE BOARD OF MEDICAL EXAMINERS

VERIFICATION OF HOSPITAL OR SURGERY CENTER PRIVILEGES

Hospital: _____
 Attn: Medical Staff Office
 Address: _____

Name: _____
 DOB: _____
 Specialty: _____
 Affiliation dates: _____

The above named physician submitted an application to obtain a medical license in Nevada. The applicant has indicated that he/she holds or has held staff privileges at your hospital. In order that the processing of the application may be completed, we ask that you provide us with the information requested below.

1. What privileges are/were extended to the applicant? _____

2. Dates of hospital privileges: From _____ To _____

3. Have staff privileges ever been limited, restricted, suspended or revoked? No _____ Yes _____
 If Yes, please explain: _____

4. Is there any derogatory information on file? No _____ Yes _____ If Yes, please explain:

5. Do your records indicate applicant having privileges at any other hospitals in your area?
 No _____ Yes _____ If Yes, please attach list.

 Signature:
 Hospital Chief-of-Staff or Administrator

 Typed Name, Title and Date
 Phone # _____
 Fax # _____
 Email _____

Please return completed form to:
 Nevada State Board of Medical Examiners
 P.O. Box 7238, Reno, NV 89510 (Mailing Address)
 1105 Terminal Way, Suite 301
 Reno, NV 89502 (Physical Address)
 Phone: (775) 688-2559

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the State of Nevada.

Medical Doctor (applicant) signature and date

Subscribed and sworn to before me this _____ day of _____, 200__.

By: _____

Notary Public for State of: _____

My Commission Expires: _____

Signature and Seal of Notary Public

If you answered affirmatively to question #12 on the Application for Licensure, submit this form to all malpractice carriers.
If more than one malpractice carrier, photocopies of the blank form may be made and used.

FORM 6

MALPRACTICE CLAIM VERIFICATION REQUEST

Insurance Carrier Information:

Name of Insured Physician: _____

Name of Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

(To be completed by verifying agency only)

Policy Number: _____

Policy Period From: _____ To: _____

****Please provide a loss history report with this verification.

Claims Experience:

Has this Physician had a settlement paid on his/her behalf?

____ No ____ Yes

If "yes", please provide the following information:

Occurrence

Date

Status

Date Closed

*Indemnity
Amount*

Description of Claim: _____

Occurrence

Date

Status

Date Closed

*Indemnity
Amount*

Description of Claim: _____

Insurance Carrier Agent:

Print Name and Title

Telephone

Signature of Agent

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way #301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the State of Nevada.

Medical Doctor (applicant) signature and date

Subscribed and sworn to before me this ____ day
of _____, 200__.

By: _____

Notary Public for State of: _____

My Commission Expires: _____

Signature and Seal of Notary Public